Washington State Department of Social & Health Services

Health and Recovery Services Administration (HRSA)

Hospice Services

Billing Instructions for Hospice Agencies, Hospice Care Centers, and Pediatric Palliative Care Providers

[Chapter 388-551 WAC Subchapter 1]

Copyright Disclosure

About this publication

This publication supersedes all previous HRSA *Hospice Billing Instructions* and Numbered Memorandum 01-76 MAA, 02-85 MAA, 03-77 MAA, and 04-54 MAA.

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Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

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Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its programs; however, HRSA's response is based solely on the information provided to the [HRSA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA's programs. [WAC 388-502-0020(2)].

Who do I contact about payments, denials, general questions regarding claims processing, or Healthy Options?

Customer Service Center
360.562.3022

Who do I contact if I'm interested in becoming a CUP Women program provider or have questions regarding CUP Women program policy?

Family Services Manager
Division of Alcohol and
Substance Abuse (DASA)
360.438.8087

HRSA CUP Women Program Manager
360.725.1950

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Who do I contact if I want to request an extended stay?

HRSA CUP Women Program Manager
Division of Program Support
Family Services Section
PO Box 45530
Olympia, WA 98504-5530
lawerle@dshs.wa.gov
360.725.1950

Where do I call/look if I have questions regarding…

Policy, payments, denials, or general questions regarding claims processing, or HRSA Managed Care?

Customer Service Center
800.562.3022, option 2

http://maa.dshs.wa.gov/provrel

Private insurance or third-party liability, other than HRSA Managed Care?

Coordination of Benefits Section
800.562.6136

Electronic Billing?

Electronic Media Claims Help Desk
360.725.1267

Internet Billing (Electronic Claims Submission)?

WinASAP

http://www.acs-gcro.com/docs/edi-winasap.php?menuItem=software

All other HIPAA transactions

https://wamedweb.acs-inc.com/wa/general/home.do

Where do I send my claims?

Hard Copy Claims:
Division of Healthcare Services
PO Box 9246
Olympia, WA 98507-9246

How do I obtain copies of billing instructions or numbered memoranda?

To view an electronic copy, visit HRSA on the web at: http://maa.dshs.wa.gov (click **Billing Instructions/Numbered Memoranda)**

-or-

To request a hard copy, visit the Department of Printing's web site at:

http://www.prt.wa.gov/ (click **General Store**)

Who do I contact if I have questions regarding…

Payments, denials, general questions regarding claims processing, HRSA managed care plans?

Visit the Customer Service Center for Providers on the web at: http://maa.dshs.wa.gov/provrel/ (click **I'm already a current provider**)

or call/fax:
800.562.3022 (toll free)
360.725.2144 (fax)

or write to:
HRSA Customer Service Center
PO Box 45535
Olympia, WA 98504-5535

Private insurance or third party liability, other than HRSA managed care plans?

Division of Eligibility and Service Delivery
Coordination of Benefits
PO Box 45565
Olympia, WA 98504-5565
800.562.6136 (toll free)

Assistance with Electronic Billing?

HRSA/HIPAA E-Help Desk
Toll free: 800.562.3022 (Option #1, then select option #4) or e-mail: hipaae-help@dshs.wa.gov

ACS EDI Gateway, Inc.
Toll free : 800.833.2051 or
http://www.acs-gcro.com/

Medications not related to the Hospice diagnosis?

Pharmacy Authorization Line
800.848.2842

How do I find out about Internet Billing (Electronic Claims Submission)?

WinASAP and WAMedWeb
http://www.acs-gcro.com/
Select *Medicaid*, then *Washington State*

All other HIPAA transactions
https://wamedweb.acs-inc.com/

To use HIPAA Transactions and/or WinASAP 2003 enroll with ACS EDI Gateway by visiting ACS on the web at:
http://www.acs-gcro.com/docs/wa-home.php?menuItem=enroll
(click **Enrollment**)

or by calling: 800.833.2051.

How do I find out about Internet Billing (Electronic Claims Submission)? (cont.)

Once the provider completes the EDI Provider Enrollment form and faxes or mails it to ACS, ACS will send the provider the web link and the information needed to access the web site. If the provider is already enrolled, but for some reason cannot access the WAMedWeb, then the provider should call ACS at 800.833.2051.

Where can I view and download rates?

Visit: http://maa.dshs.wa.gov/ProRates

How do I obtain HRSA Hospice program forms?

To **view and download** the *Medicaid Hospice 5-Day Notification* form [DSHS 13-746] and the *Pediatric Palliative Care (PPC) Referral & 5-Day Notification* form [DSHS 13-752] visit DSHS Forms and Records Management Service on the web: http://www1.dshs.wa.gov/msa/forms/eforms.html

How do I find out where my local Community Services Office (CSO) is located?

Visit the on-line CSO.

How do I find out where my local Home and Community Services (HCS) office is located?

Visit the HCS web site: http://www.aasa.dshs.wa.gov/Resources/clickmap.htm

How do I use the WAMedWeb to check on a client's eligibility status?

If you would like to check client eligibility for free, call ACS at 800.833.2051or HRSA at 866.562.188 option #4.

You may also access the WAMedWeb tutorial at: http://maa.dshs.wa.gov/WaMedWebTutor/

Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions.

Acute – Having a rapid onset, severe symptoms, and short course; not chronic.

Aging and Disabilities Services Administration (ADSA)

Authorized Representative - An individual who has been authorized to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated. See RCW 7.70.065. [WAC 388-551-1010]

Bereavement Counseling – Counseling services provided to a client's family or significant others following the client's death.

Biologicals – Medicinal preparations including serum, vaccine autotoxins, and biotechnological drugs made from living organisms and their products. [WAC 388-551-1010 and 1210]

Brief Period – 6 days or less within a 30 consecutive day period. [WAC 388-551-1010]

Certification Statement – A document that states the client's eligibility for each election period and is:

- Created and filed by the Hospice Agency for each HRSA hospice client; and
- Signed by the physician and/or hospice medical director.

Client – An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. [WAC 388-551-1010]

Continuous Home Care – Services provided for a period of 8 or more hours in a day. It may include homemaker services and home health aide services, but must be predominantly nursing care. It can be provided only during a period of *acute medical crisis* or the sudden loss of a caregiver who was providing skilled nursing care, and only as necessary to maintain the client at home. (HRSA does not reimburse for continuous home care provided to a client in a nursing facility, hospice care center or hospital.)

Counseling – Services for the purpose of helping an individual and those caring for them to adjust to the individual's approaching death. Other counseling (including dietary counseling) may be provided for the purpose of educating or training the client's family members or other caregivers on issues related to the care and needs of the client.

Department - The state Department of Social and Health Services (DSHS). [WAC 388-500-0005]

Discharge – An agency ends hospice care for a client. [WAC 388-551-1010]

Election Period – The time, 90 or 60 days, that the client is certified as eligible for and chooses to receive hospice care. [WAC 388-551-1010]

Election Statement – A written document provided by the hospice agency that is signed by the client in order to initiate hospice services.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Family – An individual or individuals who are important to, and designated in writing by, the client and need not be relatives, or who are legally authorized to represent the client. [WAC 388-551-1010]

General Inpatient (GIP) Hospice Care - Acute care that includes services administered to the client for acute pain and/or symptom management that cannot be done in other settings. In addition:

- The services must conform to the client's written plan of care (POC).
- This benefit is limited to brief periods of care delivered in HRSA-approved:
  - ✓ Hospitals;
  - ✓ Nursing facilities; or
  - ✓ Hospice care centers.

Health and Recovery Services Administration (HRSA) – The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Home - See Residence.

Home and Community Services (HCS) Offices – An Aging and Disabilities Services Administration (ADSA) office that manages the state's comprehensive long-term care system which provides in-home, residential, and nursing home services to clients with functional disabilities. [WAC 388-551-1010]

Home Health Aide – An individual registered or certified as a nursing assistant under Chapter 18.88 RCW who, ***under the direction and supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist***, assists in the delivery of nursing- or therapy-related activities, or both, to patients of a hospice agency or hospice care center. [WAC 388-551-1010]

Home Health Aide Services – Services provided by home health aides in an in-home services agency licensed to provide home health, hospice, or hospice care center services under the supervision of a registered nurse, physical therapist, occupation therapist, or speech therapist. Such care may include:

- Ambulation and exercise;
- Medication assistance level 1 and level 2;
- Reporting changes in clients' conditions and needs;
- Completing appropriate records; and
- Personal care or homemaker services and other nonmedical tasks.

[WAC 388-551-1010]

Homemaker – An individual who provides assistance in personal care, maintenance of a safe and healthy environment, and services to enable a client's plan of care to be carried out.

Hospice Agency – A person or entity administering or providing hospice services directly or through a contract arrangement to individuals in places of temporary or permanent residence under the direction of an interdisciplinary team composed of at least a nurse, social worker, physician, spiritual counselor, and a volunteer. (Note: For the purposes of these billing instructions, requirements for hospice agencies also apply to hospice care centers.) [WAC 388-551-1010]

Hospice Care Center (HCC) - A homelike noninstitutional facility where hospice services are provided, and that meets the requirements for operation under RCW 70.127.280. [WAC 388-551-1010]

Hospice Daily Rate - The dollar amount HRSA will reimburse for each day of care.

Hospice Services - Symptom and pain management provided to a terminally ill individual and emotional, spiritual, and bereavement support for the individual and individual's family in a place of temporary or permanent residence.
[WAC 388-551-1010]

Inpatient Respite Care - See Respite Care.

Institution – An establishment that furnishes food, shelter, medically-related services, and medical care to four or more persons unrelated to the proprietor. This includes medical facilities, nursing facilities, and institutions for the mentally-retarded. [WAC 388-500-0005]

Interdisciplinary Team – The following who plan and deliver care to a client as appropriate under the direction of a physician:

- Counselors;
- Home health aides monitored by a registered nurse or a therapist;
- Physicians;
- Registered nurses;
- Social workers;
- Therapists (physical, occupational, and/or speech-language);
- Volunteers; and
- Others as necessary.

[WAC 388-551-1010]

Intermittent – Stopping and starting again at intervals; pausing from time to time; periodic.

Life-Limiting Condition - A medical condition in children that most often results in death before adulthood.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Maximum Allowable – The maximum dollar amount HRSA will reimburse a provider for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CN) and Medically Needy (MN) programs.

Medical Identification Card – The document HRSA uses to identify a client's eligibility for a medical program. These cards were formerly known as Medical Assistance Identification (MAID) cards.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.
[WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Palliative – Medical treatment designed to reduce pain or increase comfort, rather than cure. [WAC 388-551-1010]

Participation - The money a client owes before eligibility for Medicaid services.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medicaid client and that consists of:

a) First and middle initials (*or* a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Pediatric Palliative Care (PPC) Case Management/Coordination - Palliative care for a child with a life-limiting condition.

Plan of Care (POC) – A written document based on assessment of individual needs that identifies services to meet these needs. [WAC 388-551-1010]

Provider or Provider of Service – An institution, agency, or person who:

- Has a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Related Conditions – Any health condition(s) that manifests secondary to, or exacerbates symptoms associated with, the progression of the condition and/or disease, the treatment being received, or the process of dying. Examples of related conditions are:

- Medication management of nausea and vomiting secondary to pain medication; and
- Skin breakdown prevention/treatment due to peripheral edema.

Remittance and Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Residence – A client's home or place of living. [WAC 388-551-1010]

Respite Care – Short-term, inpatient care only provided on an intermittent, non-routine, and occasional basis and not provided consecutively for periods of longer than 6 days in a 30-day period.

Revised Code of Washington (RCW) – Laws of the State of Washington.

Revoke or Revocation – The choice to stop receiving hospice care. [WAC 388-551-1010]

Routine Home Care – Intermittent care received by the client at their place of residence, with no restriction on length or frequency of visits, dependent on the client's needs.

Terminally Ill – The client has a life expectancy of six months or less, assuming the client's disease process runs its natural course. [WAC 388-551-1010]

Third-Party - Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. [42 CFR 433.136]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

24-hour day – A day beginning and ending at midnight. [WAC 388-551-1010]

Usual and Customary Charge - The rate that may be billed to the department for a certain service or equipment. This rate *may not exceed:*

- The usual and customary charge that a provider bills the general public for the same services; or

- If the general public is not served, the rate for the same services normally offered to other contractors.

Washington Administrative Code (WAC) Codified rules of the State of Washington.

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About the Hospice Program

What is the Hospice Program? [WAC 388-551-1000]

The HRSA Hospice program is a 24-hour a day program that allows a terminally ill client to choose physical, pastoral/spiritual, and psychosocial comfort care rather than cure. A hospice interdisciplinary team communicates with the client's non hospice care providers to ensure the client's needs are met through the hospice plan of care. Hospitalization is used only for acute symptom management.

A client, a physician, or an authorized representative under RCW 7.70.065 may initiate hospice care. The client's physician must certify the client as terminally ill and appropriate for hospice care. Hospice care is provided in the client's temporary or permanent place of residence. Hospice care ends when:

- The client or an authorized representative under RCW 7.70.065 revokes the hospice care;
- The hospice agency discharges the client;
- The client's physician determines hospice care is no longer appropriate; or
- The client dies.

Hospice care includes the provision of emotional and spiritual comfort and bereavement support to the client's family member(s).

How does a hospice agency become an HRSA-approved hospice agency? [Refer to WAC 388-551-1300]

To become an HRSA-approved hospice agency, HRSA requires a hospice agency to provide documentation that it is Medicare, Title XVIII certified by the Department of Health (DOH) as a hospice agency. An HRSA-approved hospice agency must meet the requirements in:

- Chapter 388-551 WAC Subchapter I, Hospice Services;
- Title XVIII Medicare Program; and
- Chapter 388-502 WAC, Administration of Medical Programs--Providers.

To ensure quality of care for HRSA clients, HRSA's clinical staff may conduct a hospice agency site.

How does a hospice agency become an HRSA-approved hospice care center? [WAC 388-551-1305]

- To apply to become an HRSA-approved hospice care center, HRSA requires a hospice agency to:

  - ✓ Be enrolled with HRSA as an HRSA hospice agency (see "How does a hospice agency become an HRSA-approved hospice agency?");

  - ✓ Submit a letter of request to:

    HRSA – Division of Healthcare Services
    Hospice Program Manager
    PO Box 45506
    Olympia, WA 98504-5506

  - ✓ Include documentation that confirms the agency is:

    - ➢ Medicare certified by DOH as a hospice care center; and
    - ➢ Providing one or more of the following levels of hospice care.

      - Routine home care;
      - Inpatient respite care; and
      - General inpatient care (requires a registered nurse on duty 24 hours a day, seven days a week).

- A hospice agency qualifies as an HRSA-approved hospice care center when:

  - ✓ All the requirements in this section are met; and
  - ✓ HRSA provides the hospice agency with written notification.

Hospice Election Periods [Refer to WAC 388-551-1310 (1)]

Hospice coverage is available for two 90-day election periods followed by an unlimited number of 60-day election periods. A client or a client's authorized representative must sign an election statement to initiate or reinstate an election period for hospice care.

An election to receive hospice care continues through the initial election period and subsequent election periods without a break in care as long as the client:

- Remains in the care of a hospice agency; and
- Does not revoke the election (see "What happens when a client ends (revokes) hospice care?").

Refer to page D.1 for more about Hospice **Election Statements** and the **Certification Process.**

Hospice Client Eligibility

Who is eligible? [Refer to WAC 388-551-1200 (1), (2), and (5)]

A DSHS Home and Community Services (HCS) office or Community Services Office (CSO) determines a client's eligibility for a Medical Assistance program and issues a notice of eligibility (financial award letter). A hospice agency is responsible to verify a client's eligibility with the client or the client's HCS or CSO. A client who elects to receive hospice care, and has the physician's hospice certification, is eligible to receive hospice care through HRSA's Hospice program when:

- The client presents a current Medical ID Card with one of the following identifiers:

Medical ID Card Identifier	Medical Program
CNP	Categorically Needy Program (General Assistance – Disability Determination Pending [GA-X] clients are eligible for hospice services and will be identified by the CNP identifier on their Medical ID Cards.)
CNP **SCHIP**	Categorically Needy Program – State Children's Health Insurance Program
CNP **Emergency Medical Only**	Categorically Needy Program – Emergency Medical Only
LCP-MNP	Limited Casualty Program – Medically Needy Program
LCP-MNP **Emergency Medical Only**	Limited Casualty Program – Medically Needy Program - Emergency Medical Only

- The client's physician certifies the client has a life expectancy of six months or less;
- The client elects to receive hospice care and agrees to the conditions of the "election statement" as described in "Election Statements and the Certification Process" on page D.1;
- The hospice agency serving the client:
  - ✓ Notifies HRSA within 5 working days of the admission of all clients, including:
    - ➢ Medicaid-only clients;

- ➢ Medicaid-Medicare dual eligible clients;
- ➢ Medicaid clients with third-party insurance; and
- ➢ Medicaid-Medicare dual eligible clients with third-party insurance; and

✓ Meets the hospice agency requirements listed in "What are the notification requirements for hospice agencies?" on page D.8;

- The hospice agency provides additional information for a diagnosis when HRSA requests and determines, on a case-by-case basis, the information that is needed for further review; and

- The hospice agency checks the WAMedWeb to verify the HRSA-approved hospice start-of-care date (see *Important Contacts* section).

What if the client's eligibility is pending?

1. Fax or call the client's HCS office or CSO to confirm pending eligibility. (See *Important Contacts* section.)
2. Inform the CSO or HCS office that the client is in need of hospice care.
3. Ask for priority handling of the client's care and a copy of their Medical ID Card or an award letter as soon as the client is approved.
4. The hospice agency receives a copy of the client's notice of eligibility.
5. Once the agency receives the client's notice of eligibility, notify the HRSA Hospice Program Manager of the client's start-of-care date within 5 working days (see *Important Contacts* for information on obtaining the notification form).

How do I use the WAMedWeb to check on a client's eligibility status?

If you would like to check client eligibility at no additional cost, call ACS at 800.833.2051or HRSA at 866.562.6188 option #4.

Are clients enrolled in managed care eligible for hospice services? [Refer to WAC 388-551-1200 (3)]

Clients whose Medical ID Cards have an HMO identifier in the HMO column are enrolled in an HRSA managed care plan. A client enrolled in one of HRSA's managed care plans must receive all hospice services, including nursing facility room and board, directly through that plan. The client's managed care plan is responsible for arranging and providing for all hospice services for a client enrolled in a managed care plan. The plan's 800 telephone number is located on the client's Medical ID Card. **For managed care clients, do not contact HRSA's Hospice Program Manager (e.g., fax).**

> **Note:** To prevent denials of billed claims, please check the client's Medical ID Card/WaMedWeb *prior* to scheduling services and at the *time of the service* to make sure proper authorization or referral is obtained from the managed care plan.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain, or be referred for, services via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's Medical ID Card for the PCCM. (See the *Billing* section for further information.)

> **Note:** To prevent denials of billed claims, please check the client's Medical ID Card/WaMedWeb *prior* to scheduling services and at the *time of the service* to make sure proper authorization or referral is obtained from the PCCM.

Medicare Part A [WAC 388-551-1200 (4)]

A client who is also eligible for Medicare Part A is not eligible for the hospice Medicaid daily rate through HRSA's hospice program. HRSA pays hospice nursing facility room and board for these clients if the client is admitted to a nursing facility or hospice care center and is not receiving general inpatient care or inpatient respite care.

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Hospice Coverage

What covered services, including core services and supplies, are included in the hospice daily rate? [Refer to WAC 388-551-1210]

The HRSA reimburses a hospice agency for providing covered services, including core services and supplies, through HRSA's hospice daily rate, subject to the conditions and limitations described in these billing instructions. To qualify for reimbursement, covered services, including core services and supplies included in the hospice daily rate, must be:

- Related to the client's hospice diagnosis;
- Identified by a client's hospice interdisciplinary team;
- Written in the client's plan of care (POC);
- Safe and meet the client's needs within the limits of the Hospice program; and
- Made available to the client by the hospice agency on a 24-hour basis.

> **Note:** Services are intermittent except during brief periods of acute symptom control. The client/family has 24-hour access to a registered nurse (RN)/physician.

The hospice daily rate includes the following core services that must be either provided by hospice agency staff, or contracted through a hospice agency, if necessary, to supplement hospice staff in order to meet the needs of a client during a period of peak patient loads or under extraordinary circumstances:

- Physician services related to administration of the POC.
- Nursing care provided by:
  - ✓ A registered nurse (RN); or
  - ✓ A licensed practical nurse (LPN) under the supervision of an RN.
- Medical social services provided by a social worker under the direction of a physician.
- Counseling services provided to a client and the client's family members or caregivers.

Covered services and supplies may be provided by a service organization or an individual provider when contracted through a hospice agency. To be reimbursed the hospice daily rate, a hospice agency must:

- Assure all contracted staff meet the regulatory qualification requirements;
- Have a written agreement with the service organization or individual provider providing the services and supplies; and
- Maintain professional, financial, and administrative responsibility.

> **Note:** Personal care is not a core service. A home health aide needed by a client from a hospice agency under the plan of care is different than personal care from a care-giver. Record in the client's record what services the hospice agency is providing and what Community Options Program Entry System (COPES) or personal care services are being provided by others. Document frequency and services of both to show non duplication.

The following covered services and supplies are included in the appropriate hospice daily rate as described in the "Hospice Reimbursement" section, subject to the limitations described in these billing instructions:

- **A brief period of inpatient care,** for general or respite care provided in a Medicare-certified hospice care center, hospital, or nursing facility;
- **Adult day health**;
- **Communication** with non hospice providers about care not related to the client's terminal illness to ensure the client's POC needs are met and not compromised;
- **Coordination of care**, including coordination of medically necessary care not related to the client's terminal illness;
- **Drugs, biologicals, and over-the-counter medications** used for the relief of pain and symptom control of a client's terminal illness and related conditions;

> **Note:** The provider of the drugs and biologicals bills HRSA separately for enteral/parenteral supplies only when there is a pre-existing diagnosis requiring enteral/parenteral support. This pre-existing diagnosis **must not** be related to the diagnosis that qualifies the clients for hospice.

- **Home health aide, homemaker, and/or personal care services** that are ordered by a client's physician and documented in the POC. (Home health aide services are provided through the hospice agency to meet a client's extensive needs due to the client's terminal illness. These services must be provided by a qualified home health aide and are an extension of skilled nursing or therapy services. [Refer to 42 CFR 484.36];

- **Interpreter services** as necessary for the POC;

- **Medical equipment and supplies** that are medically necessary for the palliation and management of a client's terminal illness and related conditions;

- **Medical transportation services** as required by POC related to the terminal illness;

- **Physical therapy, occupational therapy, and speech-language therapy** to manage symptoms or enable the client to safely perform activities of daily living (ADLs) and basic functional skills;

- **Skilled nursing care**; and

- **Other services or supplies** that are documented as necessary for the palliation and management of the client's terminal illness and related conditions.

The hospice agency is responsible to determine if a nursing facility has requested authorization for medical supplies or medical equipment, including wheelchairs, for a client who becomes eligible for the Hospice program. HRSA does not pay separately for medical equipment or supplies that were previously authorized by HRSA and delivered on or after the date HRSA enrolls the client in hospice.

Note: If the covered services listed above are not documented in the POC but are considered necessary by medical review for palliative care and are related to the hospice diagnosis, the hospice agency is responsible for payment.

What services are not included in the hospice daily rate?

The following services are not included in the hospice daily rate:

- Dental care;
- Eyeglasses;
- Hearing aids;
- Podiatry;
- Chiropractic services;
- Ambulance transportation, if not related to client's terminal illness;
- Brokered transportation, if not related to the client's terminal illness;
- Community Options Program Entry System (COPES) or Title XIX Personal Care Services, **if** the client is eligible for these services. Eligibility is determined by the local Aging and Disabilities Services Administration (ADSA) field office and will be **reimbursed by ADSA**; and
- Services ***not*** related to the terminal condition.

If the above service(s) are covered under the client's Medicaid program, the provider of service must follow specific program criteria and bill HRSA separately using the applicable fee schedule.

How do I request a noncovered medical service or related equipment? **[Refer to WAC 388-501-0160]**

Providers may request prior authorization (see "Important Contacts" section) for HRSA to pay for a noncovered medical service or related equipment. **This is called an exception to rule.** HRSA cannot approve an exception to rule if the exception violates state or federal law or federal regulation.

For HRSA to consider the request, sufficient client-specific information and documentation must be submitted for the HRSA medical director or designee to determine if:

- The client's clinical condition is so different from the majority that there is no equally effective, less costly covered service or equipment that meets the client's need(s); and

- The requested service or equipment will result in lower overall costs of care for the client.

The HRSA medical director or designee evaluates and considers requests on a case-by-case basis according to the information and documentation submitted from the provider. Within fifteen working days of HRSA's receipt of the request, HRSA notifies the provider and the client, in writing, of HRSA's decision to grant or deny the exception to rule.

Note: Clients do not have a right to a fair hearing on exception to rule decisions

Hospice Coverage Table

Allowable Places of Service and Hospice Revenue Codes for Pediatric Palliative Care

The following is a chart explaining where hospice care may be performed:

Place of Service / Client Residence				
Type of Service/Levels of Care	**Client's Home (AFH, BH, AL)**	**Nursing Facility (NF)**	**Hospital**	**Hospice Care Center (HCC)**
Level 1: Routine Home Care (RHC) **(651)**	Yes Not in comb w/ any other level of care	Yes Not in comb w/ 656 or 655	No	Yes Not in comb w/656 or 655
Level 2: Continuous Home Care (CHC) **(652)** Hourly nursing	Yes Not in comb w/ 651, 655, or 656	No	No	No
Level 3: Inpatient Respite **(655)** Includes R/B	No	Yes For clients not residing in NF Not in comb w/115,125, 135, 656, or 651	Yes Not in comb w/any other code	Yes For clients not residing in HCC Not in comb w/145 or 651
Level 4: General Inpatient Care (GIP) **(656)** Includes R/B	No	Yes Not in comb w/any other code	Yes Not in comb w/any other code	Yes Not in comb w/any other code
Nursing Facility (NF) R/B **(115,125,135)**	No	Yes	No	No
Hospice Care Center (HCC) **(145)** R/B Admin day rate	No	No	No	Yes Not in comb w/ 656 or 655
Pediatric Palliative Care (PPC) **(659)**	Yes Not for clients in a group home	No	No	No

Hospice Revenue Codes

Enter the following revenue codes and ***service descriptions*** in the appropriate form locators.

Revenue Code	Description of Code
115*	***Hospice (Room and Board - Private)*** Enter the words **"Room and Board"** in form locator 43. Enter the nursing facility's provider number in form locator 83.
125*	***Hospice (Room and Board - Semi-Private 2 Bed)*** Enter the words **"Room and Board"** in form locator 43. Enter the nursing facility's provider number in form locator 83.
135*	***Hospice (Room and Board - Semi-Private 3-4 Beds)*** Enter the words **"Room and Board"** in form locator 43. Enter the nursing facility's name or provider number in form locator 83 or in the remarks form locator.
145	***Hospice Care Center (Hospice Deluxe Room and Board)*** Enter the words **"Room and Board"** in form locator 43. Enter the nursing facility's provider number in form locator 83.
651	**Level 1: *Routine Home Care* (Hospice Daily Rate)**
652	**Level 2: *Continuous Home Care***
655	**Level 3: *Inpatient Respite Care***
656	**Level 4: *General Inpatient Care***

* For Revenue Codes 115, 125, and 135, download the Nursing Home Fee Schedule at: http://maa.dshs.wa.gov/ProRates/index.nursing_home_rates.html.

Note: For limitations, see **Billing** section.

Note: For hospice, you must choose one of four levels of care. Only nursing facility or hospice care center room and board can be billed with level 1. Do not bill other codes with levels 2, 3, or 4. Do not bill any other code with 659.

PPC Revenue Codes

Revenue Code	Description of Code
659	***Other Hospice Services*** (Pediatric Palliative Care (PPC) Case Management/Coordination will be reimbursed according to the fee schedule.) See below for examples of use.
659	PPC - RN
659	PPC – PT
659	PPC – OT
659	PPC – ST
659	PPC – Case Management Time (Bill the date of service each time two-hour time requirement was met.)

Hospice Services Provided *Inside* Client's Home

Revenue Codes		
651, 652, and 659 are paid according to the client's place of residence. Non-CBSA***** and out-of-state paid as "All Other Areas."		
Counties	**CBSA**	**Policy/Comments**
All Other Areas	50	
Asotin	30300	
Benton	28420	
Chelan	48300	
Clark	38900	
Cowlitz	31020	
Douglas	48300	
Franklin	28420	
Island	50	(Island County is no longer part of King County and is paid at an "All Other Areas" rate.)
King	42644	
Kitsap	14740	
Pierce	45104	
Skagit	34580	
Skamania	38900	
Snohomish	42644	
Spokane	44060	
Thurston	36500	
Whatcom	13380	
Yakima	49420	

*** CBSA = Core Based Statistical Area**

Hospice Services Provided *Outside* Client's Home

Revenue Codes		
655 and 656 are paid according to the provider's place of business. Non-CBSA and out-of-state paid as "All Other Areas."		
Counties	**County Code**	**Policy/Comments**
All Other Areas	50	
Asotin	30300	
Benton	28420	
Chelan	48300	
Clark	38900	
Cowlitz	31020	
Douglas	48300	
Franklin	28420	
Island	50	(Island County is no longer part of King County and is paid at an "All Other Areas" rate.)
King	42644	
Kitsap	14740	
Pierce	45104	
Skagit	34580	
Skamania	38900	
Snohomish	42644	
Spokane	44060	
Thurston	36500	
Whatcom	13380	
Yakima	49420	

*** CBSA = Core Based Statistical Area**

Note: See **Hospice Reimbursement** section for nursing facility and hospice care center reimbursement information.

Hospice Provider Requirements

Election Statements and the Certification Process

[Refer to WAC 388-551-1310 (2)-(5)]

Election Statements

The election statement must be filed in the client's hospice medical record within two calendar days following the day the hospice care begins and requires all of the following:

- Name and address of the hospice agency that will provide the care;
- Documentation that the client is fully informed and understands hospice care and waiver of other Medicaid and/or Medicare services;
- Effective date of the election; and
- Signature of the client or the client's authorized representative.

Hospice Certification Process

The following describes the hospice certification process:

When a client elects to receive hospice care, HRSA requires a hospice agency provider to:

- Obtain a signed written certification of the client's terminal illness; or

- Document in the client's medical file that a verbal certification was obtained and follow up a documented verbal certification with a written certification signed by:

  - ✓ The medical director of the hospice agency or a physician staff member of the interdisciplinary team; and
  - ✓ The client's attending physician (if the client has one); and

- Place the signed written certification of the client's terminal illness in the client's medical file:

  - ✓ Within 60 days following the day the hospice care begins; and
  - ✓ Before billing HRSA for the hospice services.

- For subsequent election periods, HRSA requires the hospice agency to:

  - ✓ Obtain a signed, written certification statement of the client's terminal illness; or
  - ✓ Document in the client's medical file that a verbal certification was obtained and follow up a documented verbal certification with a written certification signed by the medical director of the hospice agency or a physician member of the hospice agency; and
  - ✓ Place the written certification of the client's terminal illness in the client's medical file:
    - ➢ Within two calendar days following the beginning of a subsequent election period; and
    - ➢ Before billing HRSA for the hospice services.

When a client's hospice coverage ends within an election period (e.g. the client revokes hospice care), the remainder of that election period is forfeited. The client may reinstate the hospice benefit at any time by providing an election statement and meeting the certification process requirements.

Note: The hospice certification must specify that the client's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

The hospice agency must notify the HRSA Hospice Program Manager of the start-of-care date within 5 working days of the first day of hospice services for all HRSA-eligible clients, including clients with third-party and/or Medicare coverage. If a client has Medicaid, even if you do not plan to bill Medicaid, send HRSA a completed Medicaid 5-day Notification form [DSHS 13-746]. This is to prevent duplication of payment between Medicare and Medicaid.

What are HRSA's requirements for the hospice Plan of Care?
[WAC 388-551-1320]

A hospice agency must establish a written plan of care (POC) for a client that describes the hospice care to be provided. The POC must be in accordance with the Department of Health (DOH) requirements, as described in WAC 246-335-085, and meet the requirements in these billing instructions.

A registered nurse or physician must conduct an initial physical assessment of a client and develop the POC with at least one other member of the hospice interdisciplinary team.

At least two other hospice interdisciplinary team members must review the POC no later than two working days after it is developed.

The POC must be reviewed and updated every two weeks by at least three members of the hospice interdisciplinary team that includes at least:

- A registered nurse;
- A social worker; and
- One other hospice interdisciplinary team member.

Hospice Coordination of Care **[Refer to WAC 388-551-1330]**

A hospice agency must facilitate a client's continuity of care with nonhospice providers to ensure that medically necessary care, both related and not related to the terminal illness, is met. This includes:

- Determining if HRSA has approved a request for prescribed medical equipment, such as a wheelchair. If the prescribed item is not delivered to the client before the client becomes covered by a hospice agency, HRSA will rescind the approval [see WAC 388-543-1500];

  Example: A nursing facility orders a wheelchair for one of its clients. That client then chooses and is authorized for hospice care. The wheelchair arrives after the client has begun the first 90-day election period. The hospice agency may pay for the wheelchair or provide the medically necessary equipment. HRSA reimburses the hospice agency for the medical equipment through the appropriate hospice daily rate as described in WAC 388-551-1510 (6).

  (**Note:** It may be appropriate to rent equipment in some cases.)

- Communicating with other department programs and documenting the services a client is receiving in order to prevent duplication of payment and to ensure continuity of care. Other department programs include, but are not limited to, programs administered by the ADSA; and

- Documenting each contact with non hospice providers.

> **Note:** The POC and service plan must both show the specific duties/services each will provide to prevent duplication of services.

When a client resides in a nursing facility, the hospice agency must:

- Coordinate the client's care with all providers, including pharmacies and medical vendors; and

- Provide the same level of hospice care the hospice agency provides to a client residing in their home.

Once a client chooses hospice care, hospice agency staff must notify and inform the client of the following:

- By choosing hospice care from a hospice agency, the client gives up the right to:

  - ✓ Covered Medicaid hospice services (e.g., adult day health) and supplies received at the same time from another hospice agency; and

  - ✓ Any covered Medicaid services and supplies received from any other provider that are necessary for the palliation and management of the terminal illness and related medical conditions.

- Services and supplies are not paid through the hospice daily rate if they are:

  - ✓ Proven to be clinically unrelated to the palliation and management of the client's terminal illness and related medical conditions;

  - ✓ Not covered by the hospice daily rate;

  - ✓ Provided under a Title XIX Medicaid program when the services are similar to the hospice care services; or

  - ✓ Not necessary for the palliation and management of the client's terminal illness and related medical conditions.

A hospice agency must have written agreements with all contracted providers.

What happens when a client…

…leaves hospice care without notice? [WAC 388-551-1340]

When a client chooses to leave hospice care or refuses hospice care without giving the hospice agency a revocation statement, as required by WAC 388-551-1360, the hospice agency must do all of the following:

- Inform and notify in writing HRSA's Hospice Program Manager within 5 working days of becoming aware of the client's decision;
- Not bill HRSA for the client's last day of hospice services;
- Forward a completed copy of the Medicaid Hospice 5-Day Notification form [DSHS # 13-746] to the appropriate HCS office or CSO to notify that the client is discharging from the hospice program;
- Notify the client, or the client's authorized representative, that the client's discharge has been reported to HRSA; and
- Document the effective date and details of the discharge in the client's hospice record.

…discharges from hospice care? [WAC 388-551-1350]

A **hospice agency** may discharge a client from hospice care when the client:

- Is no longer certified (decertified) for hospice care;
- Is no longer appropriate for hospice care (see page A.1); or
- The hospice agency's medical director determines the client is seeking treatment for the terminal illness outside the plan of care.

At the time of a client's ***discharge***, the hospice agency must:

- Inform and notify in writing HRSA's Hospice Program Manager within 5 working days of the reason for discharge;
- Forward a completed copy of the Medicaid Hospice 5-Day Notification form [DSHS # 13-746] to the appropriate HCS office or CSO;
- Keep the discharge statement in the client's hospice record;
- Provide the client with a copy of the discharge statement; and

- Inform the client that the discharge statement must be:

  - ✓ Presented with the client's current Medical ID Card when obtaining Medicaid covered healthcare services, supplies, or both; and

  - ✓ Used until the department issues the client a new Medical ID Card which identifies that the client is no longer a hospice client.

…ends (revokes) hospice care? [WAC 388-551-1360]

A client or authorized representative may choose to stop hospice care at any time by signing a **revocation** statement.

The revocation statement documents the client's choice to stop Medicaid hospice care. The revocation statement must include all of the following:

- Client's (or authorized representative's) signature;
- Date the revocation was signed;
- Actual date that the client chose to stop receiving hospice care; and
- The client-specific-reason for revocation.

The hospice agency must keep any explanation supporting difference in the signature and revocation dates in the client's hospice records.

When a client **revokes** hospice care, the hospice agency must:

- Inform and notify HRSA's Hospice Program Manager within 5 working days of becoming aware of the client's decision;

- Forward a completed copy of the Medicaid Hospice 5-Day Notification form [DSHS # 13-746] to the appropriate HCS office or CSO;

- Not bill HRSA for the client's last day of hospice services;

- Keep the revocation statement in the client's hospice record;

- Provide the client with a copy of the revocation statement; and

- Inform the client that the revocation statement must be:

  - ✓ Presented with the client's current Medical ID Card when obtaining Medicaid covered healthcare services, supplies, or both; and

  - ✓ Used until the department issues the client a new Medical ID Card that identifies that the client is no longer a hospice client.

After a client revokes hospice care, the remaining days within the current election period are forfeited. The client may immediately enter the next consecutive election period. The client does not have to wait for the forfeited days to pass before entering the next consecutive election period.

…dies? [WAC 388-551-1370]

When a client dies, the hospice agency must:

- Inform and notify in writing HRSA's Hospice Program Manager within 5 working days; and

- Forward a completed copy of the Medicaid Hospice 5-Day Notification form [DSHS # 13-746] that states the date of death to the appropriate HCS office or CSO.

What are the notification requirements for hospice agencies?
[Refer to WAC 388-551-1400]

To ensure a hospice client receives quality of care, and to ensure HRSA determines accurate coverage and reimbursement for services that are related to the client's terminal illness or related conditions, a hospice agency must meet the following notification requirements. To be reimbursed for providing hospice services, the hospice agency must report to the HRSA Hospice Program Manager within 5 working days from when an HRSA client begins the first day of hospice care, or has a change in hospice status:

- The name and address of the hospice agency;
- The date of a client's first day of hospice care;

> **Note:** When a hospice agency does not notify HRSA within 5 working days of the date of the client's first day of hospice care, HRSA authorizes the hospice daily rate or nursing facility room and board reimbursement effective the fifth working day prior to the date of notification.

- A change in a client's primary physician;
- A client's revocation of the hospice benefit (home or institutional);
- The date a client leaves hospice without notice;

- A client's discharge from hospice care;
- A client who admits to a nursing facility (This does not apply to an admit for inpatient respite care or general inpatient care.);
- A client who admits to a nursing facility/hospice care center, except for GIP or respite;
- A client who dies; or
- A client who transfers to another hospice agency. Both the former agency and the current agency must provide HRSA with:

  ✓ The client's name, the name of the former hospice agency serving the client, and the effective date of the client's discharge; and

  ✓ The name of the current hospice agency serving the client, the hospice agency's provider number, and the effective date of the client's admission.

For the following two instances, the hospice agency must notify only the HCS or CSO within 5 working days from a change in hospice status when:

- A client discharges from a nursing facility; and
- A client becomes eligible for Medicare or third-party liability insurance.

HRSA does not require a hospice agency to notify the HRSA Hospice Program Manager when a hospice client is admitted to a hospital for palliative care.

Note: Failure to notify the HRSA Hospice Program Manager of a client's discharge or revocation from hospice care could result in the client being denied medically necessary services, and the provider being denied payment.

For example: The client revokes hospice care. The hospice agency fails to notify HRSA's Hospice Program Manager within 5 working days. The client and/or family attempt to get a prescription filled at the pharmacy. The pharmacist does not fill the prescription because the client is on hospice. The client or family is then forced to go without, or pay for the prescription. According to WAC, the pharmacy cannot legally force Medicaid clients to pay for their drugs when the drugs are a covered service.

Should I notify HRSA if Medicaid is not primary?

Yes! Notify HRSA even if the client has Medicare or other TPL insurance and you are not intending to bill HRSA. In order to bill HRSA, the hospice agency must ensure that the client meets Medicaid criteria.

Notify the HRSA Hospice Program Manager ANYTIME there is a change in the client's hospice ***election status***. If you need clarification or have questions, call the HRSA Hospice Program Manager (see *Important Contacts* section).

Notifying Clients of Their Rights (Advance Directives)

[42 CFR, Subpart I]

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give ***all adult clients*** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

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Hospice Reimbursement

How does HRSA determine what rate to pay?

[Refer to WAC 388-551-1510]

Note: Prior to submitting a claim to the HRSA, a hospice agency must file written certification in a client's hospice record. (Refer to "Election Statements and the Certification Process" on page D.1.)

- HRSA pays for hospice care provided to clients in one of the following settings:
  - ✓ A client's residence.
  - ✓ An HRSA-approved nursing facility, hospital, or hospice care center.
- To be paid by HRSA, the hospice agency must provide and/or coordinate HRSA-covered:
  - ✓ Medicaid hospice services; and
  - ✓ Services that relate to the client's terminal illness any time during the hospice election.
- Hospice agencies must bill HRSA for their services using hospice-specific revenue codes (see **Allowable Places of Service and Hospice Revenue Codes** section).
- HRSA pays hospice agencies for services (not room and board) at a daily rate calculated by one of the following methods:
  - ✓ Payments for services delivered in a client's residence (routine and continuous home care) are based on the county location of the client's residence for that particular client; or
  - ✓ Payments for respite and general inpatient hospice care are based on the county location of the providing hospice agency.

Note: The daily rate for authorized out-of-state hospice services is the same as for in-state non MSA hospice services.

When does HRSA pay for the client's last day of hospice care? **[Refer to WAC 388-551-1510 (6) and (9)]**

HRSA:

- Pays for routine hospice care, continuous home care, respite care, or general inpatient care for the day of death;
- Does not pay room and board for the day of death;
- Does not pay hospice agencies for the client's last day of hospice care when a client discharges, revokes, or transfers (unless the last day is also the first day of care); and
- Does not pay hospice agencies or hospice care centers a nursing facility room and board payment for:

  - ✓ A client's last day of hospice care (e.g., client's discharge, revocation, or transfer); or
  - ✓ The day of death.

How does HRSA reimburse for nursing facility residents? **[Refer to WAC 388-551-1510 (8)]**

HRSA pays nursing facility room and board payments to hospice agencies, not licensed as hospitals, at a daily rate as follows:

- Directly to the hospice agency at 95% of the nursing facility's current Medicaid daily rate in effect on the date the services were provided;

- The hospice agency pays the nursing facility at a daily rate not greater than the nursing facility's current Medicaid daily rate.

How does HRSA reimburse for hospice care center residents? **[Refer to WAC 388-551-1510 (9)]**

HRSA pays an HCC a daily rate for room and board based on the average room and board rate for all nursing facilities in effect on the date the services were provided.

Client Participation [Refer to WAC 388-551-1510]

Hospice clients may be responsible to pay for part of their care (participation). If the client is assigned participation, the hospice agency is responsible to collect (the hospice agency may contract out if it does not choose to collect) the client's monthly participation amount stated in the Notice of Action (award) letter sent by DSHS to the client. If the client is on the COPES program, the participation goes to the COPES provider. The HCS office or CSO sends a copy of the letter to the hospice agency when requested with the Medicaid Hospice 5-Day Notification form [DSHS #13-746].

Note: Do NOT bill HRSA for the participation amount. Instead, bill HRSA your usual and customary charge. See below instructions for how to indicate a client's participation amount on your claim.

The correct amount of the client's participation is the responsibility of the hospice agency and must be:

- **For Hospice Care Centers:**
  - ✓ Indicated on the UB-92 claim form in form locator 57, whether or not the HCC collects participation from the client, or HRSA may recoup the participation amount from the HCC. When billing, enter the total charges (form locator 47) minus the client participation (form locator 57) in form locator 55 (Est. Amount Due).
  - ✓ Collected by the hospice agency or HCC each month as directed by the notice of action (award letter) issued by the department; and
  - ✓ Forwarded to the HCC.
- **For Nursing Facilities:**
  - ✓ Indicated on the UB-92 claim form in form locator 57, whether or not the nursing facility collects participation from the client, or HRSA may recoup the participation amount from the nursing facility. When billing, enter the total charges (form locator 47) minus the client participation (form locator 57) in form locator 55 (Est. Amount Due);
  - ✓ Collected by the hospice agency or nursing facility (if contracted to do so) each month as directed by the notice of action (award letter) issued by the department; and
  - ✓ Forwarded to the nursing facility.

How does DSHS reimburse for clients under the COPES program? [WAC 388-551-1510 (9)]

The department's ADSA pays for services provided to a client eligible under the COPES program directly to the COPES provider and:

- The client's monthly participation amount in that case is paid separately to the COPES provider; and
- Hospice agencies must bill HRSA directly for hospice services, not the COPES program.

When does HRSA reimburse hospitals providing care to hospice clients? [WAC 388-551-1520 (1)]

HRSA pays hospitals that provide inpatient care to clients in the hospice program when the medical condition is **not** related to their terminal illness. (Refer to HRSA's current *Inpatient Hospital Billing Instructions* or *Outpatient Hospital Billing Instructions*.)

How does HRSA reimburse for the following physician services?

Administrative and Supervisory Services

Administrative and general supervisory activities performed by physicians are **included** in the hospice daily rate. These physicians are either employees of the hospice or are working under arrangements made with the hospice agency. The physician serving as the medical director of the hospice and/or the physician member of the hospice interdisciplinary team would generally perform the following activities:

- Physician participation in the establishment of plans of care;
- The supervision of care and services;
- The periodic review and updating of plans of care; **and**
- The establishment of governing policies.

Note: These activities cannot be billed separately.

Physician Services not related to the Hospice Diagnosis Provided by Physicians not Employed by the Hospice Agency to Hospice Clients
[WAC 388-551-1520 (2)]

HRSA pays providers, who are attending physicians and not employed by the hospice agency, the usual and customary charge through the Resource-Based Relative Value Scale (RBRVS) fee schedule published in HRSA's current *Physician-Related Services Billing Instructions*:

- For direct physician care services provided to a hospice client;
- When the provided services are not related to the terminal illness; and
- When the client's providers, including the hospice provider, coordinate the health care provided.

Download the Physician Related Services Fee Schedule at
http://maa.dshs.wa.gov/RBRVS/Index.html#P

Professional Services Related to the Hospice Diagnosis

Refer to the RBRVS fee schedule found in HRSA's current *Physician-Related Services Billing Instructions.*

Who can bill professional services?

HRSA reimburses for professional services only when they are billed by one of the following:

- Primary Physician;

- Hospice Agency (using Hospice Clinic # beginning with 7xxxxxx);

- Consulting physicians or those providing backup care for the primary physician**.** Consulting physicians must be coordinated with the hospice agency; or

- Radiologist/laboratory: When billing for the professional component, include **modifier 26** in field 24 D on the 1500 claim form, along with the appropriate procedure code. (See #1 or #2 below, as applicable.) Charges for the technical component of these services, such as lab and x-rays, are **included** in the hospice day rate and may not be billed separately.

What provider number do I use?

Bill HRSA for all professional services in one of the following ways:

1. When the primary physician performs the service, bill using their provider number. *Include the following information on the 1500 claim form:*

Field #	What do I need to put here?
33 – GRP#	Primary Physician's or Clinic's Provider Number

- OR -

2. When a physician, other than the primary physician, performs the service, bill using the primary physician provider number. *Include the following information on the 1500 claim form:*

Field #	What do I need to put here?
17 and 17a	Primary Physician Name or Clinic Name and Provider Number
33 – PIN#	Performing Provider Number
33 – GRP#	Hospice Agency, lab, radiology, consulting physician, or clinic provider number

How does HRSA reimburse for Medicaid-Medicare dual eligible clients? [WAC 388-551-1530]

HRSA does not pay for any hospice care provided to a client covered by Medicare part A (hospital insurance).

HRSA may pay for hospice care provided to a client:

- Covered by Medicare Part B (medical insurance); and
- Not covered by Medicare Part A.

Hospice agencies must bill:

- Medicare before billing HRSA; and
- HRSA for hospice nursing facility room and board, using the nursing facility's name or the HRSA-assigned provider number in form locator 83 on the UB-92 claim form.

Fee Schedule

You may view HRSA's **Hospice Services Fee Schedule** on-line at http://maa.dshs.wa.gov/RBRVS/Index.html

For a paper copy of the fee schedule:

- **Go to:** http://www.prt.wa.gov/ (On-line orders filled daily.) Click **General Store**. Follow prompts to **Store Lobby → Search by Agency → Department of Social and Health Services → Health and Recovery Services Administration** → desired documents; **or**

- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/ telephone 360.586.6360. (Faxed or telephoned orders may take up to 2 weeks to fill.)

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Pediatric Palliative Care Case Management/Coordination Services

About the Services [WAC 388-551-1800]

Through a hospice agency, HRSA pediatric palliative care (PPC) case management/coordination services provide the care coordination and skilled care services to clients who have life-limiting medical conditions. Family members and caregivers of clients eligible for pediatric palliative care services may also receive support through care coordination when the services are related to the client's medical needs.

Client Eligibility [WAC 388-551-1810]

Who is eligible?

To receive PPC case management/coordination services, a person must:

- Be 20 years of age or younger;
- Have a current Medical ID Card with one of the identifiers located on page B.1;
- Have a life-limiting medical condition with a complex set of needs requiring case management and coordination of medical services due to at least three of the following five circumstances:
  - ✓ An immediate medical needs during a time of crises;
  - ✓ Coordination with family member(s) and providers required in more than one setting (i.e. school, home, and multiple medical offices or clinics);
  - ✓ A life-limiting medical condition that impacts cognitive, social, and physical development;
  - ✓ A medical condition with which the family is unable to cope;
  - ✓ A family member(s) and/or caregiver who needs additional knowledge or assistance with the client's medical needs; and

- ✓ Therapeutic goals focused on quality of life, comfort, and family stability.

Are clients enrolled in managed care eligible for PPC services?
[Refer to WAC 388-551-1200 (2)]

Yes! Clients whose Medical ID Cards have an HMO identifier in the HMO column are enrolled in an HRSA managed care plan. A client enrolled in one of HRSA's managed care plans must receive all PPC services, including nursing facility room and board, directly through that plan. The client's managed care plan is responsible for arranging and providing all PPC services for a client enrolled in a managed care plan. The plan's 800 telephone number is located on the client's Medical ID Card. HRSA does not process or reimburse claims for managed care clients for services provided under the Healthy Options contract.

> **Note:** To prevent denials of billed claims, please check the client's Medical ID Card/WaMedWeb *prior* to scheduling services and at the *time of the service* to make sure proper authorization or referral is obtained from the PCCM.

Coverage **[Refer to WAC 388-551-1820]**

What is covered?

HRSA's PPC case management/coordination services cover up to 6 PPC contacts per client, per calendar month.

> **Note:** If more than 6 contacts are medically necessary, you may fax a request for additional contacts to the PPC Program Manager with the medical justification. If more than six contacts are routinely needed, the child may not be appropriate for PPC.

What is included in a PPC contact?

A PPC contact includes:

- One visit with a registered nurse, social worker, or therapist (for the purposes of these billing instructions, HRSA defines therapist as a licensed physical therapist, occupational therapist, or speech/language therapist) with the client in the client's residence to address:

  - ✓ Pain and symptom management;
  - ✓ Psychosocial counseling; or
  - ✓ Education/training;

- Two hours or more per month of case management or coordination services to include any combination of the following:

  - ✓ Psychosocial counseling services (includes grief support provided to the client, client's family member(s), or client's caregiver prior to the client's death);

  - ✓ Establishing or implementing care conferences;

  - ✓ Arranging, planning, coordinating, and evaluating community resources to meet the child's needs; and

  - ✓ Visits lasting 20 minutes or less (for example: visits to give injections, drop off supplies, or make appointments for other PPC-related services); and

  - ✓ Visits not provided in the client's home.

Note: Two hours of case management equals one contact and one visit equals one contact. You can get 6 contacts with any combination. Unbilled case management hours do not carry over to the next month.

What is not covered?

- HRSA does not pay for a PPC contact when a client is receiving similar services from any of the following:

  - ✓ Home Health program;
  - ✓ Hospice program;
  - ✓ Private duty nursing (private duty nursing can subcontract with PPC to provide services);
  - ✓ Disease case management program; or
  - ✓ Any other department program that provides similar services.

- HRSA does not pay for a PPC contact that includes providing counseling services to a client's family member or the client's caregiver for grief or bereavement for dates of service after a client's death.

How does a hospice agency become an HRSA-Approved PPC Provider? [WAC 388-551-1830]

> **Note:** This section does not apply to providers who already are HRSA-approved PPC providers.

To apply to become an HRSA-approved PPC provider, a provider must:

- Be an HRSA-approved hospice agency (see page A.1 and A.2); and

- Submit a letter to HRSA's Hospice/PPC program manager (see *Important Contacts* section) requesting to become an HRSA-approved provider of PPC and include a copy of the provider's policies and position descriptions with minimum qualifications specific to pediatric palliative care.

Provider Requirements [WAC 388-550-1840]

An eligible provider of PPC case management/coordination services must do all of the following:

- Meet the conditions in "How does a hospice agency become an HRSA-approved hospice agency?" on page A.1 of these billing instructions;

- Confirm that a client meets the eligibility criteria on page F.1 prior to providing PPC services;

- Obtain a written referral to HRSA's PPC program manager from the client's physician;

- Determine and document in the client's medical record the medical necessity for the initial and ongoing care coordination of PPC services;

- Document in the client's medical record:

  - ✓ A palliative plan of care (POC) (a written document based on assessment of a client's individual needs that identifies services to meet those needs.);
  - ✓ The medical necessity for those services to be provided in the client's residence; and
  - ✓ Discharge planning.

- Provide medically necessary skilled interventions and psychosocial counseling services by qualified interdisciplinary hospice team members.

- Assign and make available a PPC case manager (nurse, therapist, or social worker) to implement care coordination with community-based providers to ensure clarity, effectiveness, and safety of the client's POC.

- Notify the HRSA PPC Program Manager within 5 working days from the date of occurrence of the client's:

  - ✓ Date of enrollment in PPC;
  - ✓ Discharge from the hospice agency or PPC when the client:

    - ➢ No longer meets PPC criteria;
    - ➢ Is able to receive all care in the community;
    - ➢ Does not require any services for sixty days; or
    - ➢ Discharges from PPC to enroll in HRSA's Hospice program;

  - ✓ Transfer to another hospice agency for pediatric palliative care services; or
  - ✓ Death.

Note: The Referral for Pediatric Palliative Care (PPC) [DSHS # 13-752] is located at http://www1.dshs.wa.gov/msa/forms/eforms.html. A sample notification form is included at the end of these billing instructions.

- Maintain the client's file which includes the POC, visit notes, and all of the following:

  - ✓ The client's start of care date and dates of service;
  - ✓ Discipline and services provided (in-home or place of service);
  - ✓ Case management activity and documentation of hours of work; and
  - ✓ Specific documentation of the client's response to the palliative care and the client's and/or client's family's response to the effectiveness of the palliative care (e.g., the client might have required acute care or hospital emergency room visits without the pediatric palliative care services).

- Provide when requested by HRSA's PPC program manager, a copy of the client's POC, visit notes, and any other documents listing the information identified above.

If HRSA determines the documentation in the POC or attachment to the POC does not meet the criteria for a client's PPC eligibility or does not justify the billed amount, any payment to the provider is subject to recoupment by HRSA.

Note: Therapy services may be provided in outpatient settings and billed with the client's Medical ID Card. Some children are not appropriate for outpatient therapy and would be best served in the home. The documentation on the PPC POC would note the medical necessity.

PPC Revenue Code

Revenue Code	Description of Code
659	***Other Hospice Services*** (Pediatric Palliative Care (PPC) Case Management/Coordination will be reimbursed according to the fee schedule.) See below for examples of use:
659	PPC – RN
659	PPC – PT
659	PPC – OT
659	PPC – ST
659	PPC – Case Management Time (Bill the date of service each two-hour time requirement was met.

Reimbursement

How does HRSA pay for PPC services?

HRSA pays providers for PPC case management/coordination services per contact using the average of statewide Metropolitan Statistical Area (MSA) home health care rates for skilled nursing, physical therapy, speech-language therapy, and occupational therapy. Revenue code **659** is reimbursed per visit as follows:

MSA	Maximum Allowable	MSA	Maximum Allowable
Bellingham	$87.40	Spokane	$87.40
Bremerton/Kitsap	77.14	Tacoma	77.14
Olympia	83.16	Vancouver	83.16
Richland/Kennewick	79.87	Yakima	79.87
Seattle/Everett	88.07	Non-MSA	88.07

HRSA makes adjustments to the reimbursement rate for PPC contacts when the legislature grants a vender rate change. New rates become effective as directed by the legislature and are effective until the next rate change. The reimbursement rate for authorized out-of-state PPC services is the same as the in-state, non MSA rate.

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Billing

How do I bill for general services? [WAC 388-551-1500]

Note: Refer to Place of Service table on page G.1 for combinations of codes allowed.

All services, supplies, and equipment related to a client's terminal illness and related conditions are included in the hospice daily rate through one of the following four levels of hospice care.

Bill HRSA using your hospice **7-digit** provider number beginning with 399. All claims for these services must be submitted as an institutional claim in the 837I format or on a UB-92 claim form (see *Completing the UB-92 Claim Form*).

Refer to combination of codes allowed in section G.

- ***Routine home care*** includes services for daily care administered to the client at the client's residence. The services are not restricted in length or frequency of visits, are dependent on the client's needs, and are provided to achieve palliation or management of acute symptoms.

- ***Continuous home care*** includes services administered to the client in order to maintain the client at the client's residence. Continuous home care addresses a brief period of medical crisis for an acute skilled care need for an unstable client, consists predominantly of nursing care, and is limited to:

  - ✓ A minimum of eight hours of acute care provided during a 24-hour day. This care may be interrupted *(*for example, four hours in the morning and four hours in the evening is acceptable); **and**
  - ✓ Nursing care that must be provided by a registered or licensed practical nurse for more than half the period of care; **and**
  - ✓ Homemaker, home health aide, and attendant services that may be provided as supplements to the nursing care; **and**
  - ✓ In-home care only (not care in a nursing facility, hospice care center, or hospital).

  For every hour or part of an hour of continuous care, the hourly rate is reimbursed to the hospice *up to 24 hours a day*. Bill continuous care as a separate line entry on the UB-92 claim form for each day this level of care is provided.

- ***Inpatient respite care*** includes room and board services administered to a client in an HRSA-approved hospice care center, nursing facility, or hospital in order to provide relief to the client's primary caregiver and is limited to:

  - ✓ No more than six (6) consecutive days; and
  - ✓ A client not residing in a hospice care center, nursing facility, or hospital.

  HRSA will deny the **entire claim** if the hospice agency bills for more than six (6) consecutive days of respite care.

  Bill HRSA for the sixth and subsequent days at the routine home care rate.

  Itemize the individual days of inpatient respite care services on the **UB-92 claim form**.

  If the client dies during the six-day respite period, bill HRSA the respite rate for the ***ending date of service***.

- ***General inpatient hospice care*** includes services administered to the client for pain control or acute chronic symptom management that cannot be provided in other settings. In addition:

  - ✓ The services must conform to the client's written plan of care (POC).

  - ✓ This benefit is limited to brief periods of six (6) days or less of care delivered in HRSA-approved:

    - ➢ Hospitals;
    - ➢ Nursing facilities; or
    - ➢ Hospice care centers.

  - ✓ There must be clear documentation in the client's medical record to support a brief period of need for pain control or acute symptom management services.

  Bill the day of discharge from the hospital, nursing facility, or hospice care center at the routine home care rate. If the client dies in the hospital, nursing facility, or hospice care center, bill HRSA the general inpatient rate for the ending date of service.

What is the time limit for billing? [Refer to WAC 388-502-0150]

HRSA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. HRSA has two timeliness standards for initial claims and resubmitted claims.

- ***Initial Claims***

  - ✓ HRSA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

    - ➢ The date the provider furnishes the service to the eligible client;
    - ➢ The date a final fair hearing decision is entered that impacts the particular claim;
    - ➢ The date a court orders HRSA to cover the services; or
    - ➢ The date DSHS certifies a client eligible under delayed[1] certification criteria.

  - ✓ HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

    - ➢ DSHS certification of a client for a retroactive[2] period; or
    - ➢ The provider proves to HRSA's satisfaction that there are extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

- ***Resubmitted Claims/Appeals Process***

  Providers may **resubmit, modify, or adjust** any timely initial claim, **except** prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: HRSA does ***not*** accept any claim for resubmission, modification, or adjustment after the time period listed above. HRSA **does** accept additional information for medical review with a resubmitted claim as an appeal when a provider feels the claim was denied in error.

- The time periods do not apply to overpayments incurred by the provider and due to DSHS. After the allotted time periods, a provider may not refund overpayment amounts to HRSA by claim adjustment. The provider must refund overpayment amounts to HRSA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ HRSA does not pay the claim.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee**.**

Exception: If billing Medicare Part B crossover claims, bill the amount submitted to Medicare.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in form locator #83 on the UB-92 claim form; and
- Enter the seven-digit, HRSA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in form locator #83 when you bill HRSA, the claim will be denied.

How do I bill for clients who are eligible for both Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid, you must first submit a claim to Medicare within its time limitations. HRSA may make an additional payment after Medicare reimburses you.

All HRSA hospice requirements and limitations are the same whether the client is eligible for:

- Medicare and Medicaid; or
- Medicaid only.

Medicare Part A

Medicare Part A covers hospice care in full.

Medicare/Medicaid clients in nursing facilities

The nursing facility and the hospice provider must comply with the conditions of participation as noted in the *Reimbursement* section under Hospice clients who are nursing facility residents.

Hospice providers must bill:

- Medicare for hospice services provided to Medicare/Medicaid clients; and
- Medicaid for nursing facility room and board using the 837I format or the UB-92 claim form.

The client may be required to contribute toward the cost of the nursing facility room and board rate. (See the explanation under the *Reimbursement* section.)

Medicare Part B/Professional Services

The hospice agency may bill HRSA for services to clients who are *only* eligible for Medicare Part B. The hospice agency must indicate that the client has only Medicare Part B coverage in *field 19* on the 1500 crossover claim form. HRSA needs your Medicare provider number on file to properly process Medicare Part B crossover claims.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their Medical ID Card in addition to QMB)

- If Medicare ***and*** Medicaid cover the service, HRSA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare ***and not Medicaid*** covers the service, HRSA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

- If Medicaid covers the service and Medicare does not cover the service, HRSA will reimburse for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, HRSA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare ***and not Medicaid*** covers the service, HRSA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

For QMB-Medicare Only:
If **Medicare does not** cover the service, HRSA will not reimburse the service.

After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to HRSA for any supplemental Medicaid payment. When the words, *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to HRSA or a private insurer.

If **Medicare has paid** and the Medicare crossover claim does not appear on the HRSA Remittance and Status Report within 30 days of the Medicare statement date, you should bill HRSA on the 1500 Claim Form.

REMEMBER! You must submit your claim to HRSA within 6 months of the Medicare statement date.

If **Medicare denies** a service, bill HRSA using the 1500 claim form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical ID Card. An insurance carrier's time limit for claim submissions may be different from HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA;
- Attach the insurance carrier's statement or EOB;
- If rebilling a hard copy claim , list the ICN on the UB-92 claim form (don't attach the RA); or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the *Comments* field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on HRSA's website at http://maa.dshs.wa.gov, select **Provider Publications/Fee Schedules**, then select **Billing Instructions**, then select *General Info Booklet*. Carrier codes are listed there. You may also call Coordination of Benefits at 800.562.6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, **for at least 6 years from the date of service** or longer if required by federal or state law or regulation.

A provider may contact HRSA with questions regarding HRSA's programs. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs. (Refer to WAC 388-502-0020[2])

UB-04 Claim Form

Attention! HRSA accepts only the new UB-04 Claim Form.

- **On March 1, 2007**, HRSA began accepting both the new UB-04 and the old UB-92 claim forms.
- **As of May 23, 2007**, HRSA accepts only the new UB-04 claims form. HRSA will return all claims submitted on the UB-92 claim forms.

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee at: http://www.nubc.org/index.html.

For more information, read # Memorandum 06-84.

To see a sample of the UB-04 Claim Form, see the *General Information Booklet*.

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Completing the 1500 Claim Form

Attention! HRSA now accepts the new 1500 Claim Form.

- **On November 1, 2006,** HRSA began accepting the new 1500 Claim Form (version 08/05).
- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 Claim Form.

Note: HRSA encourages providers to make use of electronic billing options.
For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 Claim Form. You may download this booklet from HRSA's website at: http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html or request a paper copy from the Department of Printing (see Important Contacts section).

The following 1500 claim form instructions relate to **Hospice Services Billing Instructions**. Click the link above to view general 1500 Claim Form instructions.

For questions regarding claims information, call HRSA toll-free:
800.562.3022

1500 Claim Form Field Descriptions

Field No.	Name	Field Required	Entry
19.	**Reserved for Local Use**	When applicable.	If the client has no Part A coverage, enter the statement "Client has Medicare Part B coverage only" in this field.

Continued next page

Field No.	Name	Field Required	Entry
24B.	**Place of Service**	Yes	These are the only appropriate code(s) for Washington State Medicaid: **Code Number** — **To Be Used For** 12 — Client's Residence 21 — Inpatient hospital 23 — Emergency room 24 — Outpatient hospital office or ambulatory surgery center 31 — Nursing facility 34 — Hospice care center 99 — Other
24C.	**Type of Service**	No	

Completing the Medicare Part B/Medicaid Crossover 1500 Claim Form

The 1500 Claim Form (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide. The numbered boxes on the claim form are referred to as ***fields***. A number of the fields on the form do not apply when billing the HRSA. Some field titles may not reflect their usage for this claim type. Use the instructions below to complete the 1500 Claim Form for crossover claims.

The 1500 Claim Form, used for Medicare/Medicaid Benefits Coordination, *cannot* be billed electronically.

General Instructions

- Use an original, red and white 1500 Claim Form (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional 1500 Claim Form.
- All information must be entered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the 1500 Claim Form.
- Attach a complete, legible Medicare EOMB or the claim will be denied.

Field No.	Name	Field Required	Entry
1A.	**Insured's I.D. No.**	Yes	Enter the Medicaid Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical ID Card. This information is obtained from the client's current monthly Medical ID Card consisting of the client's: a) First and middle initials (a dash [-] *must* be used if the middle initial is not available). b) Six-digit birthdate, consisting of *numerals only* (MMDDYY). c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for

Field No.	Name	Field Required	Entry
			the remainder before adding the tiebreaker. d) An alpha or numeric character (tie breaker). *For example:* ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB. ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.
2.	**Patient's Name**	Yes	Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).
3.	**Patient's Birthdate**	Yes	Enter the birthdate of the Medicaid client. **Sex**: Check **M** (male) or **F** (female).
4.	**Insured's Name (Last Name, First Name, Middle Initial)**	When applicable.	If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.
5.	**Patient's Address**	Yes	Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*).
9.	**Other Insured's Name**		Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.
9a.			Enter the other insured's policy or group number *and* his/her Social Security Number.
9b.			Enter the other insured's date of birth.
9c.			Enter the other insured's employer's name or school name.
Please Note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are **inappropriate** entries for this field.			
9d.			Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).
10.	**Is Patient's Condition Related To**	Yes	Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

Field No.	Name	Field Required	Entry
11.	**Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**	Primary insurance - when applicable	This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.
11a.	**Insured's Date of Birth**	Primary insurance – when applicable.	Enter the insured's birthdate, if different from *field 3.*
11b.	**Employer's Name or School Name**	Primary insurance - when applicable	Enter the insured's employer's name or school name.
11c.	**Insurance Plan Name or Program Name**	Primary insurance - when applicable	Show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*
11d.	**Is There Another Health Benefit Plan?**	Required if the client has secondary insurance.	Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*.
19.	**Reserved For Local Use**	Yes	**When Medicare allows services, enter *XO* to indicate this is a crossover claim.**
22.	**Medicaid Resubmission**	When applicable.	If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. [The ICN number is the claim number listed on the Remittance and Status Report (RA).] Also enter the three-digit denial Explanation of Benefits (EOB) from the RA.
24.			**Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional 1500 Claim Form**.
24A.	**Date(s) of Service**	Yes	Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2005 = 100405).

Field No.	Name	Field Required	Entry
24B.	**Place of Service**	Yes	These are the only appropriate code(s) for Washington State Medicaid: **Code Number** — **To Be Used For** 12 — Client's Residence 21 — Inpatient hospital 23 — Emergency room 24 — Outpatient hospital office or ambulatory surgery center 31 — Nursing facility 34 — Hospice care center 99 — Other
24C.	**Type of Service**	No	No longer required.
24D.	**Procedures, Services or Supplies CPT/HCPCS**	Yes	Enter appropriate code and Coinsurance.
24E.	**Diagnosis Code**		Enter appropriate diagnosis code for condition.
24F.	**$ Charges**	Yes	Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.
24G.	**Days or Units**	Yes	Enter **1**.
24K.	**Reserved for Local Use**	Yes	Enter Medicare payment per item.
26.	**Your Patient's Account No.**	No	Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading Patient Account Number.
27.	**Accept Assignment**	Yes	Check **yes.**
28.	**Total Charge**	Yes	Enter the sum of your charges. Do not use dollar signs or decimals in this field.

Field No.	Name	Field Required	Entry
29.	**Amount Paid**	Yes	Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple 1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**
30.	**Balance Due**	Yes	Enter the **Medicare Total Payment**. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple 1500 Claim Forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**
32.	**Name and Address of Facility Where Services Are Rendered**	Yes	Enter Medicare Statement Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**
33.	**Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**	Yes	Enter the supplier's *Name, Address,* and *Phone #* on all claim forms. Enter your seven-digit ***clinic*** provider number here.

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